RISPERDAL M-TAB
MEDICAL NECESSITY INFORMATION SHEET

With Few Exceptions Approval Is For 3 Months – Patients Must Fail Retrial Of Regular Risperdal Just Prior To Expiration Of Approval Before A New Request For Risperdal M-Tab Will Be Considered For Continuing Approval.

Patient's Name:_____ Pt's 9 Digit IDPA#:_____

Patient's Birth Date: _____ Diagnosis:_____

Long Term Care Facility:_____ LTC Phone #: _____

PATIENT'S CLINICAL STATUS: (Circle Degree of Severity)
Agitated: + + + + **Paranoid: + + + +** **Catatonic: + + + +**

First Request For M-Tab? [ ]Yes [ ] No **Requested Daily Dose:_____Mg.**

Has Oral Solution of Risperdal been tried unsuccessfully? **Yes[ ] No[ ]**

INDICATION FOR RISPERDAL M-TAB:
[ ] Inability To Swallow Any Oral Medications - ETIOLGY:[ ] Organic [ ] Psychogenic

[ ] Oral Aversion To All Medications: Refusal [ ] Cheeking [ ] Spitting [ ]

_____DEA # _____ Phone #_____
Prescribing Physician's Name (Please Print)

_____ _____
Physician's Signature Date OR Nurse /P.A's Sig. For Dr. Date

PHARMACY NAME & PHONE NO._____

PHARMACY PROVIDER NO._____

RISPERDAL M-TAB NDC # _____

^^^^^^^ COMPLETE THE INFORMATION ABOVE FOR ALL REQUESTS ^^^^^^^

FOR REAPPROVAL REQUESTS COMPLETE THE FOLLOWING

⇒Since Risperdal M-Tab Started, Patient Has Had Unsuccessful Trial of Regular Risperdal or Risperdal Oral Solution. Yes [ ] No [ ] Date of Trial:_____

INFORMATION MUST BE COMPLETE OR FORM WILL BE RETURNED

PLEASE FAX TO: MEDICAL COMMITTEE 217-524-7264

THIS INFORMATION IS CONFIDENTIAL AND FOR USE ONLY BY IDPA PERSONNEL INVOLVED IN THE PRIOR APPROVAL PROCESS **Revised 01/23/2004**